Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: ABSOLUTE PAIN RELIEF MED CENTER 6776 SOUTHWEST FRWY 175 HOUSTON, TX 77074	MFDR Tracking #:	M4-09-B176-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: **53** WAL MART ASSOCIATES INC	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The services were preauthorized."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $0.00*
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Please note that the health care provider was reimbursed for physical therapy approved in accordance with preauthorization # 875581.01 dated 10/16/08. The approval was for three additional sessions of physical therapy 97140, 97110, 97035, 97032. Please review the attached preauthorization letter and EOR's. The provider was paid for three sessions that were performed on 10/17/08, 10/23/08 and 10/27/08. The health care provider references TDI-DWC Rule 134.600(G)(1), which reads, "A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the carrier in accordance with Labor Code §408.0042. (1) The request shall be in the form of a treatment plan for a 60 day timeframe." This rule would not be applicable in this case. The carrier is not disputing compensability. The physical medicine rendered on date of service 10/31/08 exceeded the preauthorization and therefore no additional allowance is recommended."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
10/31/08	97032 ** N/A	1 thru 8	$0.00
10/31/08	97035 ** N/A	1 thru 8	$0.00
10/31/08	97140 ** N/A	1 thru 8	$0.00
10/31/08	97110 ** N/A	1 thru 8	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and 28 TAC Section 134.203, titled *Medical Fee Guideline for Professional Services*. The Guideline shall be effective for professional medical services provided on or after March 1, 2008.

* The Requestor did not list a sought amount.
** The Requestor did not list the GP modifier as submitted on the bill.

1. These services were denied by the Respondent with reason code "39 – Services denied at the time authorization/pre-certification was requested ", "5057 – The healthcare provider requested preauthorization; however, the insurance carrier denied approval (according to chapter 134).", "193 – original payment decision is being maintained. This claim was processed properly the first time", "198 – payment denied/reduced for exceeded precertification/authorization." "5081 – reduction or denial of payment resulting after a reconsideration was completed." and "5170 – The healthcare provider has exceeded the preauthorized services."
2. In reviewing the bill submitted by the Requestor, the disputed Current Procedural Terminology (CPT) codes were billed with modifier "GP". The Requestor did not list the "GP" modifier on the DWC-60 table nor did the Requestor list a sought amount. 28 TAC Section 133.307(c)(2)(C) states in part: Requests for medical fee dispute resolution (MDR) shall include: the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division.
3. The Requestor's request for reconsideration letter signed by "Collections Manager" is reviewed. The letter is referencing Rule 134.600 stating pre-authorization is not required for an examination when the treatments are rendered and are reasonable and medically necessary within a 60 day time frame and that the charges are well within the pre-auth period. The Requestor's DWC-60 table of disputed services is reviewed. Under the column "Requestor's Rationale for Increased Reimbursement of Refund" the requestor stated "The services were preauthorized. This contradicts the Requestor's request for reconsideration letter.
4. The Requestor submitted an authorization approval which indicates that 6 rehab visits were approved on 5/7 and 6 more visits approved on 8/4 for a total of 12. The approval also includes a request for 6 additional visits. Dr. Figueroa was contacted on 10/16/08 and negotiations for 3 additional visits were approved with a start date of 10/16/08 thru 11/21/08 for CPT codes 97140, 97110, 97035 and 97032.
5. The Carrier submitted explanation of benefits (EOB's) for dates of service 10/17/08, 10/23/08 and 10/27/08 showing payment for CPT codes 97140, 97110, 97035 and 97032 thus using the 3 additional visits that were approved. This indicates that the date of service, 10/31/08 is a fourth visit which falls outside the preauthorization granted by the Carrier.
6. 28 TAC Section 134.600(p)(5) states in part: Non-emergency health care requiring preauthorization includes: physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS).
7. The Division made a phone call to the Provider's office on 9/22/09 asking for the Requestor contact "JR". Jose who identified himself as the office manager stated JR was unavailable but that he would review the information submitted in the dispute and return the call shortly. The call was not returned on 9/22/09 or on 9/23/09. The Division placed another call to the Provider's office on 9/24/09 and was told by Natalie that Jose was not available. No phone call has been received by the Division at the time this decision is being rendered to discuss the merits of the dispute.
8. Therefore, based on the information submitted in this dispute, reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, 134.203, 134.600 and 133.307
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor Medical Fee Dispute Resolution	10/1/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.